Attachment A
Glossary

Administrative Costs- The costs incurred by a carrier, such as an HMO, for administrative services such as claims processing, billing and enrollment, etc. Administrative costs can be expressed as a percentage of premiums or on a pm/pm basis.

ASP (Application Service Provider) –A name given to a computing approach whereby enterprises access over the Internet to software applications and related services that would otherwise have to be located in the enterprise's own computers. The services include: specialized applications that would be expensive to install and maintain within the enterprise's own technical environment and remote access servicing for the users of an enterprise.

Capitation-This term usual refers to a negotiated per capita rate to be paid periodically. The recipient of the cap rate is responsible for delivery or arrangement of all health services required for the covered person(s) under the conditions of the contract.

Carve out-A decision to purchase separately a service, which is typically a part of an indemnity or MCO plan. Example: an MCO may 'carve out' behavioral health benefit and utilize a select vendor to supply these services.

Credentialing-A review process to approve a provider who applies to participate in a health plan. Specific criteria are utilized to evaluate initial and ongoing participation in the plan panel.

COB (Coordination of Benefits)- The management of the payment of services when multiple insurances are in effect.

Community Rating-A method of determining a premium structure that is influenced not by the expected level of benefit utilization, but by expected utilization by the population as a whole.

Co-pay-A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as a $10 office visit co pay.

Data Warehouse-The terminology used to identify the storing of data in a segregated computer that allows the use of reporting tools.

Electronic Data Exchange-The computer-to-computer exchange of business or other information between two organizations (trading partners.)

Enrollment-The total number of covered persons in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership.

Federal qualification-A designation made by the Centers for Medicaid and Medicare Services, of HHS, after conducting an extensive evaluation of an HMO's entire method of doing business. An organization must be federally qualified to participate in certain government cost contracts.

HEDIS-**Health Plan Employer Data Information Set**-A series of quality measures of health plan performance, i.e. care access and effectiveness, immunizations, financial stability, etc.

HIPAA (Health Insurance Portability and Accountability Act)-An act passed in 1996 that speaks to standardization of the billing of medical claims, confidentiality of personal and medical information, provisions for health insurance coverage, etc.

IVR (Interactive Voice Response)- An automated call system that provides information by the caller entering numbers over the telephone.

IPA (Independent Provider Association)-A structure that allows physicians of multiple and different specialties, i.e. family practice, internal medicine, pediatrics, obstetrics/gynecology, to contract with an HMO on a capitated basis.

IS, IT, MIS-**Information Systems, Information Technology, Management Information Systems Department**. Acronym(s) used to identify the department responsible for computer operations.

LAN (Local Area Network)- The networking of computers in a manner that allows information, files, printers, etc. to be shared.

Managed Care-A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost effective health care.

MCO-**Managed Care Organization**-Commonly used term to identify an HMO or similar type organization that practices the facilitator approach to providing care.

NCQA (National Committee on Quality Assurance)-The body responsible for accrediting managed care organizations.

Outsourcing-The terminology used to describe contracting with a third party for all hardware, software and professional services normally rendered by an internal information systems department

Per Member Per Month (PMPM)-The unit of measure related to each effective member for each month the member was effective.

POS (Point of Service)-An insurance product or rider that allows members the freedom to seek services at a preferred provider that may or may not be in a formal network.

PPO-Preferred Provider Organization. Delivery system structure utilized in self-funded employer programs that allow providers to be paid on a fee for service basis. Employees/dependents are free to select providers within the network. Should the participant obtain service outside of the network, a co pay normally applies.

Referral Pool-A fund normally created on an age/sex basis used to pay specialty care.

Refractive Benefit-Refers to the medical benefit associated with vision exams and glasses.

TPA (Third Party Administrator)-The name used to describe the management, claims processing, utilization review, general administrative services provided to self-insured employer groups.

Utilization Management (UM)-A process of integrating review and case management of services in a cooperative effort with other parties, including patients, providers and payers.

Utilization Review (UR)- A formal assessment of the medically necessity, efficiency, and /or appropriateness of health care services and treatment on a prospective, concurrent or retrospective basis.